PRACTICE OBSERVED

Practice Research

Interim discharge summaries: How are they best delivered to general practitioners?

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Abstract

All patients discharged from a medical ward during four months were randomly assigned to one of two groups. In one group the patients were given their interim discharge summary for delivery to their general practitioner by hand; in the other group the summary was posted by the hospital. Of the 289 summaries sent by either method, 279 (97%) arrived at the general practitioner's surgery. A mean (median) time of two (one) days elapsed before arrival when summaries were delivered by hand and a mean (median) of four and a half (four) days when they were posted; at least 55% of summaries delivered by hand arrived within one day of the day of discharge compared with 8% of those posted.

If all interim discharge summaries were given to patients to deliver communication between hospitals and general practitioners would be accelerated and considerable savings might be made.

Introduction

"If patients are to receive the best care in the most effective manner, then doctors' communication must be detailed, prompt and clear."[1] Within a few days of a patient's discharge from this hospital the patient's general practitioner should receive an interim discharge summary, which gives details of the admission, diagnosis, treatment, and follow up arrangements. This summary is completed by the junior medical staff of the ward and, at the specific and recently reiterated request of the local medical committee, is posted to the general practitioner's surgery. We wondered whether any advantages, including rapidity of communication, might result from changing this system to one in which patients were given the summary at discharge and asked to deliver it to their general practitioner as soon as possible. We report a study that explored this.

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Methods

Consecutive patients admitted to a general medical ward of this hospital were considered for entry to the study. On every fourth day the ward received unselected adults admitted as medical emergencies from the entire Nottingham catchment area of 650 000 residents. These admissions covered the whole range of medical conditions and ages and contributed 85% of the patients studied. The remaining 15% of patients studied had been admitted for elective investigations, particularly for cardiac problems. Patients were excluded from the study if they were admitted while under the care of a consultant who was not participating in the study, as might happen on a busy "take" day with an overflow of patients from other wards; if they died; or if they were transferred to another ward or hospital before discharge. Eligible patients were assigned at admission to a group whose interim discharge summaries were to be posted to their general practitioner (postal delivery group) or to a group who took their interim discharge summaries to their general practitioner by hand (hand delivery group) or by the use of alternate numbers in the ward ledger. The date of discharge was recorded in the ledger.

At discharge patients in the hand delivery group were handed their interim discharge summary in a sealed envelope after it had been prepared by junior medical staff. They were told to deliver it to their general practitioner and this instruction was reinforced by the following note on the envelope:

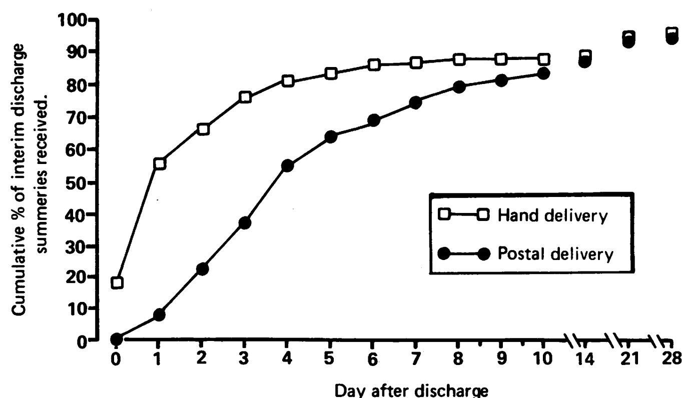
BY HAND—DO NOT POST—Please have this envelope delivered to your doctor's surgery address as soon as possible. The contents include a clinical summary of your admission for your doctor.

The interim discharge summary for each patient randomised to the postal delivery group was attached to the patient's notes and left for medical staff to

complete in the usual way. Once completed, it was placed with outgoing post from the ward and collected by the internal post service. The policy of the hospital was that it was then franked as first class and posted. A copy of the summary was filed at the back of each patient's case notes.

Included with each interim discharge summary was an addressed, freepost, individually numbered reply card, on which the general practitioner was asked to note the date of arrival of the summary at the surgery before posting it back to us.

The date of arrival of the summary at the surgery was compared with the date of discharge of the patient. If a reply card had not been received within 21 days of the date of discharge the surgery was contacted by telephone on up to two occasions over a week to ascertain whether the summary had arrived and, if so, whether the date of arrival was known. In this way we identified summaries that failed to arrive. If a summary had not arrived within four weeks of the date of discharge we checked that it had been written and posted by looking for the copy in the case notes. Patients assigned to the hand delivery group were telephoned to see whether they had received and delivered the summary.



Cumulative percentage of interim discharge summaries delivered by hand or post arriving at surgeries of general practitioners.

Results

Table I shows the number of patients admitted consecutively between May and August 1987 who were considered to be eligible for entry to the study and the reasons for excluding 106 of them. A total of 294 patients were randomised into the hand delivery (153) and the postal delivery (141) groups; table II shows details of these randomised patients.

TABLE I—*Patients eligible for study and reasons for exclusion*

	Delivery group		
	Total	Hand	Postal
Patients considered	400	200	200
Patients excluded	106	47	59
Died	23	12	11
Transferred to another ward	38	16	22
Admitted under care of another consultant	44	19	25
Still an inpatient at end of study	1		1
Patients included	294	153	141

TABLE II—*Details of two groups of patients studied*

	Delivery group	
	Hand (n=153)	Postal (n=141)
No (%) of men	77 (50)	66 (47)
Mean age (range) (years)	59 (17-89)	57 (14-89)
Mean duration (range) of admission (days)	5·6 (1-32)	5·1 (1-41)
No (%) discharged:		
By day 1	16 (10)	19 (13)
By day 2	45 (29)	46 (33)
After day 2	92 (61)	76 (54)

TABLE III—*Fate of interim discharge summaries by group*

	Delivery group		
	Total (n=294)	Hand (n=153)	Postal (n=141)
Summaries not sent	6	1	5
Summaries sent	288	152*	136
Summaries received by general practitioner:			
Reply cards returned spontaneously	238	125	113†
Arrival of summaries confirmed by telephone	40	17	23
Arrival date determined	13	5	8‡
Arrival date uncertain	27	12	15‡
Total	278	142	136*
Summaries considered to be lost§	10	5	5

*Includes five summaries intended for hand delivery that had to be posted.
†Includes three summaries posted instead of delivered by hand.
‡Includes one summary posted instead of delivered by hand.
§Not arrived 28 days after patient discharged from hospital.

Table III shows the fate of the interim discharge summaries of patients in both groups. Five patients allotted to the hand delivery group were not given their summaries at discharge; the summaries were posted instead. The times of arrival of these summaries were therefore included with the results for the postal delivery group. Summaries were not completed for six patients; in one case this was because the general practitioner was unknown and in the others because of clerical error. Reply cards were received from general practitioners after the arrival of 238 (83%) of the summaries; telephone inquiries confirmed the arrival of 40 more, so that 97% of the summaries arrived at their destination.

The figure shows the cumulative percentage of summaries arriving by day after discharge. The mean (median) time to arrival was two (one) days for summaries delivered by hand and four and a half (four) days for those delivered by post. Ten summaries (4%) did not arrive at the surgery within four weeks after discharge; the records showed that all had been written. For five of those, which had been designated for postal delivery, we were unable to explain their failure to arrive. For the remaining five, which had been designated for delivery by hand, one patient insisted that she had delivered it on the day of discharge, although it could not be found at the surgery; one patient had moved, and neither he nor his new general practitioner could be traced; one patient had registered with a new general practitioner three days after discharge, after taking an overdose; in one case the date of discharge was recorded in the general practitioner's notes after a consultation but the summary could not be found, and in the last case no explanation was found.

Discussion

Interim discharge summaries have always been sent by post from hospitals in Nottingham because the local medical committee considered that patients would not deliver them reliably. We are not aware of any evidence for this belief.

We thought that asking patients to deliver their own summaries might have considerable advantages. Firstly, if the summary is taken by the patient it must be completed before discharge, rather than left to accumulate with others for a few days before completion. In this study doctors completing the summaries preferred the new system, explaining that the information was fresh in their minds, which made the summaries easier to complete. Secondly, if a patient delivers the summary the general practitioner is more quickly informed of the admission, as a full discharge summary may take some time to arrive. The general practitioner would then know whom to contact about the patient if the need arose early after discharge. If this need arose very early after discharge the attending doctor (whether the patient's own doctor, a partner, or a deputising doctor) could be given the (as yet undelivered) summary and would therefore be able to assess the problem in the light of the information in it. Finally, on purely economic grounds, large savings in postage would be made if all patients discharged delivered their summary by hand.

Previous studies showed that the average time between a patient being discharged from hospital and an interim discharge report arriving at a surgery is 2·9-4·3 days,[2-4] although it is not clear whether the reports were posted or delivered by hand. In our study the mean time to arrival of the summary was two days when it was delivered by hand and four and a half days when it was posted.

Evans *et al* showed that only 10% of interim reports arrived within what they referred to as "the only acceptable arrangement"—namely, one day after discharge[2]; we found that 55% of summaries delivered by hand were received by the general practitioner within one day of discharge, compared with 8% of those posted. Tulloch *et al* thought that the interim summary should have arrived by at most four days after discharge[4]; in this study 81% of summaries delivered by hand and 55% of those posted arrived by the fourth day. Dover and Low-Beer, comparing the delivery of summaries by post or by hand, reported that the median time to arrival was reduced from seven and a half to two and a half days when the reports were delivered by hand.[5] In our study the median time was reduced from four days to one when patients delivered their summaries.

This study also showed that patients could be trusted to deliver their summaries by hand. Fraser *et al* found within their practice that general practitioners had received no information about 8% of their patients who had required emergency admission more than four weeks earlier.[3] In this study only 4% of the interim summaries had not arrived within four weeks after discharge. The fear that patients cannot be relied on to deliver their summaries is not supported by our finding that only five of 147 summaries were apparently "not delivered" by patients (four if the summary said to have been delivered but which could not be found is excluded). Postal delivery did not seem to be more reliable as five (4%) of summaries that were posted did not arrive.

More than 50 000 patients are discharged from this hospital each year; if all patients delivered their interim discharge summary more than £9000 would be saved on the cost of postage each year.

Although a study such as this has methodological problems, we do not believe that they invalidate the conclusions. The need for the summaries that were delivered by hand to be completed before discharge may have influenced the completion of the summaries sent by post. Our observations during the study suggested that there was a "knock on" effect, which reduced the time taken for the junior house officers to complete the summaries sent by post. We had no control over the portering and postal services of the hospital and relied on twice daily collections from the ward on weekdays. We were unable to assess any delays in this system, but as we intended to compare the postal system as it operates now with personal delivery by patients we think that our conclusions are justified.

We believe, therefore, that asking patients to take interim discharge summaries to their general practitioners personally is reliable and rapid and could result in considerable financial savings.

We thank Professor J R Hampton and Dr R G Wilcox for allowing us to include their patients; ward receptionist Christine Morrell and nursing staff of ward D56; the junior medical staff, who completed the interim discharge summaries; and the general practitioners and their receptionists who returned the reply cards.

References

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4 Tulloch AJ, Fowler GH, McMullan JJ, Spence JM. Hospital discharge reports: content and design. *Br Med J* 1975;iv:443-6.
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ONE HUNDRED YEARS AGO

The programme of the business of the meeting of the General Medical Council for Tuesday next, May 10th, commences with the consideration of the important question of the application of the Apothecaries' Society of London to the Council for the appointment of examiners. We have little or nothing to add to what we said on this subject last week; and although Dr. Struthers will probably not be prevented from bringing forward the inconsistent and illogical motion of which he has given notice, it may be assumed that this motion will meet with but little support, and that the Council will not be deterred from doing its obvious duty to the profession and the public. A letter which we have received from an eminent correspondent blessed with a good memory calls attention to the frequent change of attitude and opinion, in this matter, by Dr. Struthers. But for this there are many political precedents, and inconsistency now-a-days is the smallest of political sins. The question, however, is one which really does not depend upon any advocate, however eminent and respected, and Dr. Struthers has great claims to both of these qualifications, but on the evident and bare justice of the case, and the urgent necessities of the profession; the general practitioner—too little represented in the Council, not at all in the Colleges—would suffer, as we demonstrated beyond all dispute, irretrievable loss from the injustice which Dr. Struthers proposes to inflict on the Society which is the bulwark of the privileges of the general practitioner in England, and the main protection of the public against quacks and prescribing chemists. It is all the more necessary that this barrier should be firmly maintained because, as will be seen in another column, the Bill which the Pharmaceutical Society is now promoting, proposes to give to the pharmaceutical chemists in the future a theoretical education in materia medica, which, unless carefully watched, and even when carefully watched, may very easily afford that "little knowledge," which is dangerous and even poisonous to some minds, and which might seem to give some quasi-parliamentary sanction to an assumption of medical knowledge, and tend greatly to increase counter-practice, and prescribing and visiting by chemists. The attention of the General Medical Council will be called to this subject by a communication from the Chairman of the Parliamentary Bills Committee; but it is doubtful how far it can or will interfere. At any rate, we hope that it may be trusted not to increase the existing difficulties of the general practitioners throughout England, and not to commit the outrageous inconsistency and gross injustice which would be involved in refusing to nominate surgical examiners under the provisions of the Act of 1886, as requested.

It is quite evident that the two Colleges are either indifferent on this subject, or do not feel themselves called upon to take any other step in the matter than that which concerns their own interests. They consider it "unnecessary and unadvisable" for themselves to enter into conjunction with the Apothecaries' Society, and that is their last word on the matter. Higher and larger considerations than those of their corporate necessities and advisabilities do not seem to enter into their consideration, and are not referred to. This is the way with privileged corporations. It is, it may be hoped, far otherwise with the General Medical Council. It has a great duty to the whole profession and to the public, and that duty will certainly not be fulfilled unless it forthwith exercises what it ought to consider as a purely ministerial function by nominating the required examiners in the form laid down by the Act.

The case of the Apothecaries' Society of Ireland will follow. It rests upon a far narrower foundation, and is much more open to question, but it will possibly be found that the College of Physicians of Ireland has greatly facilitated the work of the Council by a letter which it addressed to that body on April 26th, and in which it announces that if "the General Medical Council proceed to register Licentiates of the Apothecaries' Hall of Dublin under the Medical Act of 1886, on the basis of a qualifying examination held by the Apothecaries' Hall as a medical corporation in combination with a corporation authorised to grant a diploma in respect of surgery, or on the basis of a qualifying examination held by the Apothecaries' Hall in conjunction with assistant examiners under Section 5 of the said Act, the President and Fellows of the King and Queen's College of Physicians in Ireland will take the steps advised by counsel to restrain the General Medical Council from so registering Licentiates of the Apothecaries' Hall, Dublin." We believe that many members of the Council consider that this would be a very convenient mode of testing and settling the question raised. The legal question involved will then be settled in the course of law, and the General Medical Council would thus far be relieved from an embarrassing question which appears to be full of technical difficulties, and as to which there is a wide conflict of opinion.

Subsequent business of the Council will include the discussion of reports from the Executive Committee in regard to Visitation and Inspection of Examinations; from the Procedure Committee; from the Income and Expenditure of the Curriculum Committees. The Council will also proceed to elect inspectors of examinations in accordance with the resolutions passed by the Council on February 22nd, 1887, and to this the attention of members of the profession desiring such appointments should be at once directed.

(*British Medical Journal* 1887;i:998)